

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items 18b & c G550 12/16/80 dad										STATE OF MARYLAND														
FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE														
CERTIFICATE OF DEATH										REG. NO. 0 27109														
1 DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a DATE OF DEATH MONTH DAY YEAR					2b HOUR									
Ralph C.					Adkins					Aug. 26, 1980					M									
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 UNDER 1 YEAR			8 UNDER 24 HRS											
Male		Caucasian		Oct. 21, 1910			69 YRS			MONTHS DAYS			HOURS MIN											
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH																
Md.		U.S.A.						Worcester MD																
10 CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b KIND OF BUSINESS OR INDUSTRY									
Berlin					Rt. 4, Box 303					Crane operator					Construction									
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b INSIDE CITY LIMITS?														
13a STATE										13b YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
Md.										Rt 4														
14 FATHER'S NAME										15 MOTHER'S MAIDEN NAME														
FIRST MIDDLE LAST										FIRST MIDDLE LAST														
Clayton T. Adkins										Pearl M. Butler														
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)					17 INFORMANT					ADDRESS									
No					212-12-3936					Mrs Beatrice C. Adkins					Berlin Rt 4 Box 303 Md									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
IMMEDIATE CAUSE (a):										4140														
DUE TO, OR AS A CONSEQUENCE OF										Arteriosclerotic Heart Disease year														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										(b) cellular lesion														
DUE TO, OR AS A CONSEQUENCE OF										(c) Arteriosclerosis														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																								
Obvious lung disease																								
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?					20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
										YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f LOCATION STREET CITY OR TOWN COUNTY STATE														
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																								
22b SIGNATURE										DEGREE					22c DATE SIGNED									
J.G. Green										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					8/29/80									
22d PHYSICIAN'S NAME (TYPE OR PRINT)										22e ADDRESS														
J.G. Green										Salisbury MD														
23a BURIAL, CREMATION, REMOVAL (SPECIFY)					23b DATE					23c NAME OF CEMETERY OR CREMATORY					23d LOCATION CITY OR TOWN COUNTY STATE									
Burial					8/30/80					Sunset Memorial Park					Berlin Wor. Md.									
24 FUNERAL DIRECTOR NAME										24b ADDRESS					25a DATE REC'D. BY REGISTRAR					25b REGISTRAR'S SIGNATURE				
Anna A. Burlage										108 Williams St, Berlin Md					SEP 8 1980					[Signature]				

BP

2010

2010



215 Ohio Ave

21801

2010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIA S. CAMARDESE			2a. DATE OF DEATH MONTH 10 DAY 11 YEAR 80			2b. HOUR 8:20 AM					
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH 5 DAY 29 YEAR 91		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		# UNDER 1 YEAR MONTHS DAYS 		# UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.					
10. CITY OR TOWN OF DEATH Worcester		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nurs. Home, Rt. 3, Bx. 1113, Berlin, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md 13c. COUNTY Worcester 13d. CITY OR TOWN Ocean City			13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13f. STREET ADDRESS #6 141st St.					
14. FATHER'S NAME FIRST Anthony MIDDLE LAST Camardese				15. MOTHER'S MAIDEN NAME FIRST Marie MIDDLE LAST 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 206-20-1629		17. INFORMANT ADDRESS Ocean City, Md. Joseph Camarese-Son #6 141st St.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 4375 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIAC ARRHYTHMIA (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE							
19a. DATE OF OPERATION 10/10		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR MONTH DAY 19 YEAR P.M. 		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 			
22a. I certify that (I) (this hospital) attended the deceased from 8/24 1980 to 10/11 1980 and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul A. Scott, MD				DEGREE MD		22c. DATE SIGNED 10/11/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. SCOTT, MD				22e. ADDRESS 24 BROAD ST. BERLIN, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10-11-80		23c. NAME OF CEMETERY OR CREMATORY Georgetown Med. School		23d. LOCATION CITY OR TOWN Washington, D.C. COUNTY D.C. STATE D.C.	
24. FUNERAL DIRECTOR Metropolitan Funeral Service Alexandria, Va.				25a. DATE REC'D. BY REGISTRAR OCT 17 1980			
				25b. REGISTRAR'S SIGNATURE Henry McBurney			

10-11-10

Male
Italy

Ed
Ocean City

Anthony
Joseph Cameron - son of John & Mary
Ocean City, Md.

Removal 10-11-10 Georgetown, D.C. School

Protestant Episcopal Service Association

OCT 12 1910

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
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30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27111	
1. FOR STATE REGISTRAR		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI-DEATH MATED		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		Russell		Hudson		Cullen		X 10 17 1980		8 a.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
Male	White	12-13-17	62 YRS.			10 17 1980		10 17 1980		9:30 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Washington, DC		USil		WIDOWED		DIVORCED		Worcester County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Ocean City		301 Atlantic Avenue		Owner/Manager		Hotel					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Florida		Monroe		Key Largo		YES X NO		Box 456			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Russell W. Cullen		Maybelle H. Cullen		218-20-1451		Anne T. Cullen		Key Largo, Fla			
16b. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16c. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
No				Anne T. Cullen		Key Largo, Fla					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease											
4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
N/A										YES NO X	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
				STREET							
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.											
22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner.											
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED					
William G. Andrade		M.D. Hlt. Dep.				10/17/80					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		14 - 93rd St. Coastal Hwy.		Ocean City, Md.		21842			
William G. Andrade											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Cremation		10-18-80		Cape Henlopen Crematorium		Lewes, Sussex		Delaware			
24. FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Ulrich Funeral Home		Berlin, Maryland		OCT 20 1980		R. J. [Signature]					

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John T. Sullivan, Esq.

151-2-215

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Abstract: The purpose of this study was to determine the effect of a 12-week training program on the physical fitness and health of sedentary, middle-aged men. The program consisted of three sessions per week, each lasting 45 minutes. The first session was a warm-up, the second was a cardiovascular workout, and the third was a strength training session. The participants were divided into two groups: a control group and a training group. The control group did not participate in the program, while the training group completed the program. The results showed that the training group had significantly higher levels of physical fitness and health than the control group at the end of the 12-week program. The training program was effective in improving the physical fitness and health of sedentary, middle-aged men.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 27112			
1. DECEASED NAME (TYPE OR PRINT) DAVIS Billie BURTON DAVID				2a. DATE OF DEATH MONTH DAY YEAR 10 19 80			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 5 02		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Snod Hill		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harrison House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Virginia Accomack				13b. COUNTY Chancock		13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM ERNEST BURTON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DRAPER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 234-228902		17. INFORMANT ADDRESS P.O. Box 846 AUGUSTINE DAVIS INVERNESS, FLA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 429.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Coronary Disease (c) Chronic Coronary Disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/25 , 19 78 , to 10/19 , 19 80 , that (I) (we) lost saw the deceased at 5/17 , 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Thomas J. Jones DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/19/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. J. Jones				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/21/80		23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE CHANCOK ACCOMACK VA	
24. FUNERAL DIRECTOR John J. Williams				ADDRESS P.O. Box 527 PARISLEY, VA.		25a. DATE REC'D. BY REGISTRAR OCT 27 1980	
				25b. REGISTRAR'S SIGNATURE Robert McCreedy			

2113

1927

1927

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

80

27113

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

William T. Gladden

2a. DATE OF DEATH MONTH DAY YEAR

10-17-80 7:30 P.M.

3. SEX

M

4. RACE

W

5. DATE OF BIRTH

MONTH DAY YEAR
12 28 91

6. AGE (IN YEARS LAST BIRTHDAY)

88 YRS.

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS DAYS HOURS MIN

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Worcester

MD.

10. CITY OR TOWN OF DEATH

Snow Hill

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Harrison House Nursing Home

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Druggist

12b. KIND OF BUSINESS OR INDUSTRY

Drug Store

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Virginia13b. COUNTY
Accomack13c. CITY OR TOWN
Painter

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

Painter, Va. 23420

14. FATHER'S NAME

William H. Gladden

15. MOTHER'S MAIDEN NAME

Maggie Boole Gladden

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

W.W. # 1

225-40-4629

17. INFORMANT

Doris C. Gladden

ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4292

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/17/80, 19 80, to 10/17/80, 19 80, that (I) (we) lost saw the deceased alive on 10/17/80, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE

Thomas H. Jones M.D.

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐22c. DATE SIGNED
10/18/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

THOMAS H. JONES, M.D.

22e. ADDRESS

112 Pearl St., Snow Hill, Md 21863

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

10-19-80

23c. NAME OF CEMETERY OR CREMATORY

Belle Haven Cemetery

23d. LOCATION CITY OR TOWN

Belle Haven, Accomack, Va.

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Guy J. Doughty

ADDRESS

Box 633 Exmore, Va.

25a. DATE REC'D. BY REGISTRAR

OCT 24 1980

25b. REGISTRAR'S SIGNATURE

Doughty

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten signature and date at the bottom left.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Birth may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 27114	
1. DECEASED NAME (TYPE OR PRINT) <i>Mamie W. Aldridge</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>October 17 1980</i>		2b. HOUR <i>11:45</i> AM
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>12 16 90</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Atlantic Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Worce</i> MD.		10. CITY OR TOWN OF DEATH <i>Snow Hill</i>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shantley Hall Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Accomack</i>		13c. CITY OR TOWN <i>New Church</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John B. Watson</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary E. Thornton</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>224-92-3191</i>		17. INFORMANT ADDRESS <i>Mrs William Dwyer, New Church, Va.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>1629</i> IMMEDIATE CAUSE (a) <i>Thrombogenic CA of Myocardium</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>7/30</i> , 19 <i>80</i> , to <i>10/17</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>10/14</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Thomas H. Jones M.D.</i>		DEGREE		22c. DATE SIGNED <i>10/17/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>THOMAS H. JONES, M.D.</i>		22e. ADDRESS <i>112 Pearl St Snow Hill Md 21553</i>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <i>Burial</i>		23b. DATE <i>10-19-1980</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Nelson Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>New Church Accomack Va</i>		24. FUNERAL DIRECTOR NAME <i>Walt</i>		25. DATE REC'D. BY REGISTRAR <i>OCT 22 1980</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Temperanceville Va 25442</i>		25b. REGISTRAR'S SIGNATURE <i>Betsy McCreary</i>			

10-11-1981

10-11-1981

1 - FOR STATE REGISTRAR

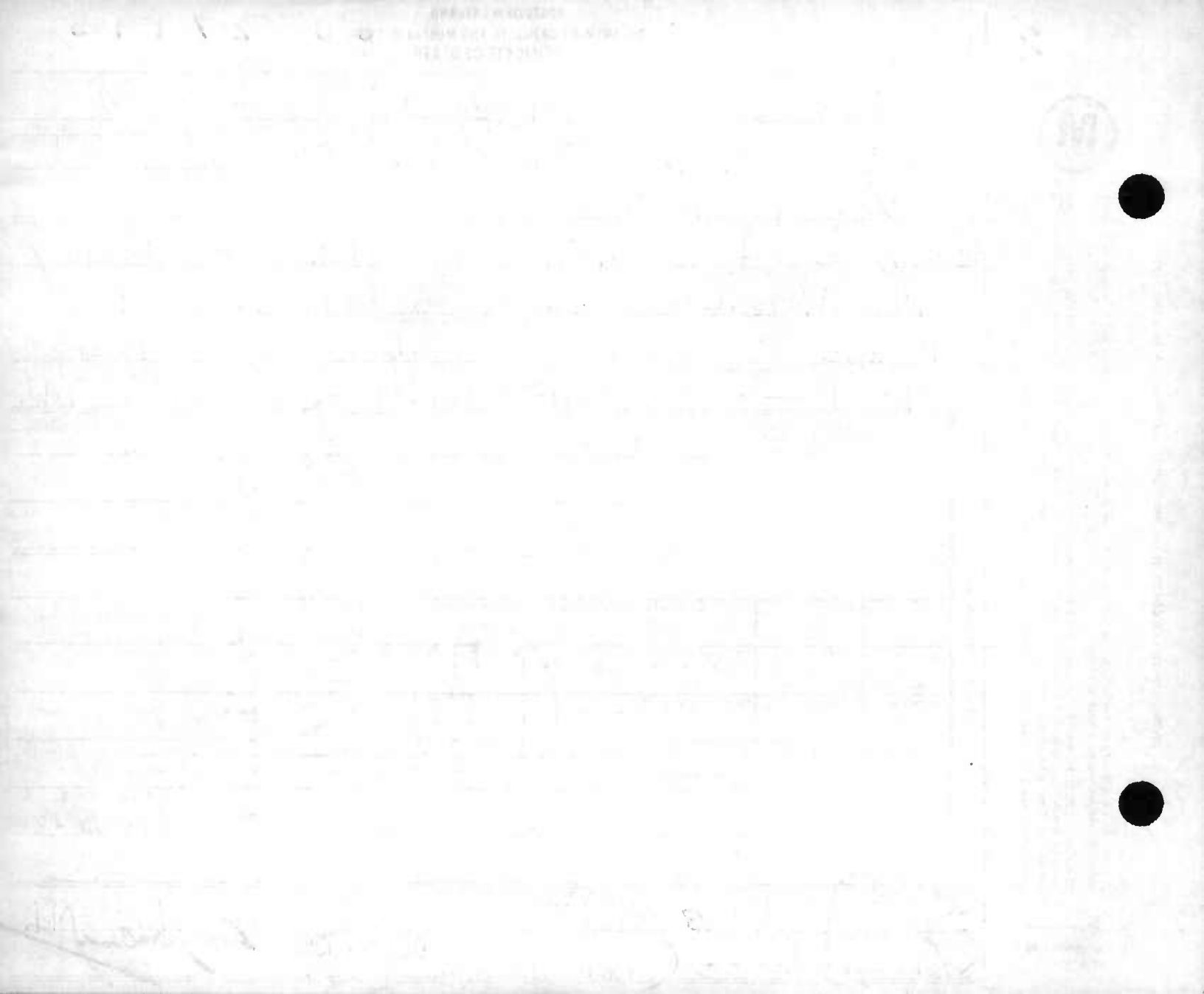
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Elmoses				Harvey, Sr.	Oct. 7, 1980						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Negro		Jan. 13, 1926		54		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		11. KIND OF BUSINESS OR INDUSTRY	
Va.		U.S.A.				Worcester		Laborer		Factory	
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15. INSIDE CITY LIMITS?		16. STREET ADDRESS		17. CITY OR TOWN	
Pocomoke		Home - Rural		Md. Worcester Pocomoke		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 2, Bx. 331			
18. FATHER'S NAME		19. MOTHER'S MAIDEN NAME		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		21. SOCIAL SECURITY NO.		22. INFORMANT		23. ADDRESS	
Moses		Cathleen Parker		No		231-18-8113		Mabel Harvey		Rt. 2 Bx. 331 Pocomoke, Md.	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		25. IMMEDIATE CAUSE (a)		26. DUE TO, OR AS A CONSEQUENCE OF (b)		27. DUE TO, OR AS A CONSEQUENCE OF (c)		28. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
410-		Acute myocardial infarction						29. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY?		33. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		34. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		35. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
36. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		37. TIME OF INJURY		38. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		39. LOCATION		40. CITY OR TOWN		41. COUNTY	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		STREET		CITY OR TOWN		COUNTY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		10-16-80	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS									
DONALD J. AMARAL		CHINCOTEAGUE, VA									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY	
Burial		10-13-80		St James Cem.		Pocomoke		Wor.		Md.	
24. FUNERAL DIRECTOR		25. NAME		26. ADDRESS		27. DATE RECEIVED BY REGISTRAR		28. SIGNATURE		29. DATE	
James L. ...		New Church, Va.				OCT 27 1980					

MEDICAL CERTIFICATION

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 0 2 7 1 1 6			
1. DECEASED NAME (TYPE OR PRINT) James Eddie Hastings				2a. DATE OF DEATH MONTH DAY YEAR Oct. 5, 1980			
2b. HOUR 9:15 P.M.		3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 13 1924	
6. AGE (IN YEARS LAST BIRTHDAY) 56		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		8. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.	
10. CITY OR TOWN OF DEATH Ocean City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Golf Course Road Rt. 1		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY General Painting	
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Ocean City		14. FATHER'S NAME FIRST MIDDLE LAST Unknown	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hastings		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 218-16-8199		17. INFORMANT ADDRESS Mrs Evelyn V. Hastings Rt. 1, Box 249 Ocean City, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) congestive heart failure 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from Sept. 28, 1980 to Oct. 5, 1980 , that (I) (we) last saw the deceased alive on Sept. 28, 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Rodney A. W. Enrich				DEGREE MD.		22c. DATE SIGNED 10/9/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WENRICH				22e. ADDRESS KAY AVE. SALISBURY Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/9/80		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. CITY OR TOWN Berlin STATE Md.	
24. FUNERAL DIRECTOR NAME Anna A. Butcher ADDRESS 108 Williams St. Berlin, Md.				25. DATE REC'D. BY REGISTRAR OCT 14 1980 SIGNATURE Barbara K. Brady			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

27117

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FRED A HELMS		2a. DATE OF DEATH MONTH 10 DAY 14 YEAR 80		2b. HOUR 11 45 AM
3. SEX Male	4. RACE W	5. DATE OF BIRTH MONTH 12 DAY 19 YEAR 23		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD
10. CITY OR TOWN OF DEATH Pocomoke Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stockton Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) weigh master	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE md		13b. COUNTY Worcester	13c. CITY OR TOWN Pocomoke	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Fred MIDDLE LAST Helms		15. MOTHER'S MAIDEN NAME FIRST Manilla MIDDLE LAST Shoemaker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 183-18-6018		17. INFORMANT Pearl Helms ADDRESS Route 5, Box 20 Pocomoke City, Maryland
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA of PANCREAS 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that (I) (this hospital) attended the deceased from September 19 80 , to October 19 80 , that (I) (we) last saw the deceased alive on September 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Paul R Fleury		DEGREE MD		22c. DATE SIGNED 10/14/80
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL FLEURY		22e. ADDRESS 305 10th Street Pocomoke City Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/17/80	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION CITY OR TOWN Hanover	COUNTY Yorks STATE Pa.
24. FUNERAL DIRECTOR NAME Scott S. Melson		ADDRESS Pocomoke City, Maryland		25. DATE REC'D. BY REGISTRAR OCT 21 1980

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MEDICAL CERTIFICATION

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BP



[Handwritten signature]

DO NOT WRITE

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FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Esther Howell Kenly			2a. DATE OF DEATH MONTH DAY YEAR Oct. 8 1980			2b. HOUR 5:15 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 8 1891		6. AGE (IN YEARS LAST BIRTHDAY) 89		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Gas.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD.			
10. CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 203 Washington St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Berlin		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 203 Washington St.	
14. FATHER'S NAME FIRST MIDDLE LAST Charles - Howell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ta Lula - Williams							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-32-7239		17. INFORMANT ADDRESS Glenn H. Kenly, 203 Washington St. Berlin, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Chronic Coronary Disease (b) Chronic Coronary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Coronary Disease									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/12 19 80 to 10/8 19 80 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 10/6 19 80 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.									
22b. SIGNATURE Thomas L. Jokes M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/10/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS L. JOKES, M.D.			22e. ADDRESS 112 Pearl St. Snow Hill, Md. 21863						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/10/80		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Episcopal Cem.		23d. LOCATION CITY OR TOWN Berlin COUNTY Wor STATE Md.			
24. FUNERAL DIRECTOR NAME Anna A. Burkett			ADDRESS 408 Williams St. Berlin, Md.			25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE Rita J. [Signature]	

BP

Oct 4 1903

Esther Howell

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 0 2 7 1 1 9

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) OLENIA M. LEWIS			2a. DATE OF DEATH MONTH DAY YEAR October 27, 1980			2b. HOUR 6:50 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-6-96		6. AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? America		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Worcester City MD.			
10. CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Pittsville									
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM BRADFORD					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE HALES				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-52-8020		17. INFORMANT ADDRESS EDITH PHILLIPS, WILLARDS, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (c) DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) DEHYDRATION, ADVANCED AGE.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/26/80 to 10/27/80, that I (we) lost saw the deceased alive on 10/27/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE Paul A. Scott				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED 10/30/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. SCOTT, MD				22e. ADDRESS 24 BROAD STREET, BALTIMORE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/31/80		23c. NAME OF CEMETERY OR CREMATORY ST. JOHNS CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE POWELLVILLE, WICO, MD.			
24. FUNERAL DIRECTOR Peter Whaley, Del.				25a. DATE REC'D. BY REGISTRAR NOV 3 1980		25b. REGISTRAR'S SIGNATURE Peter Whaley			

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(M)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

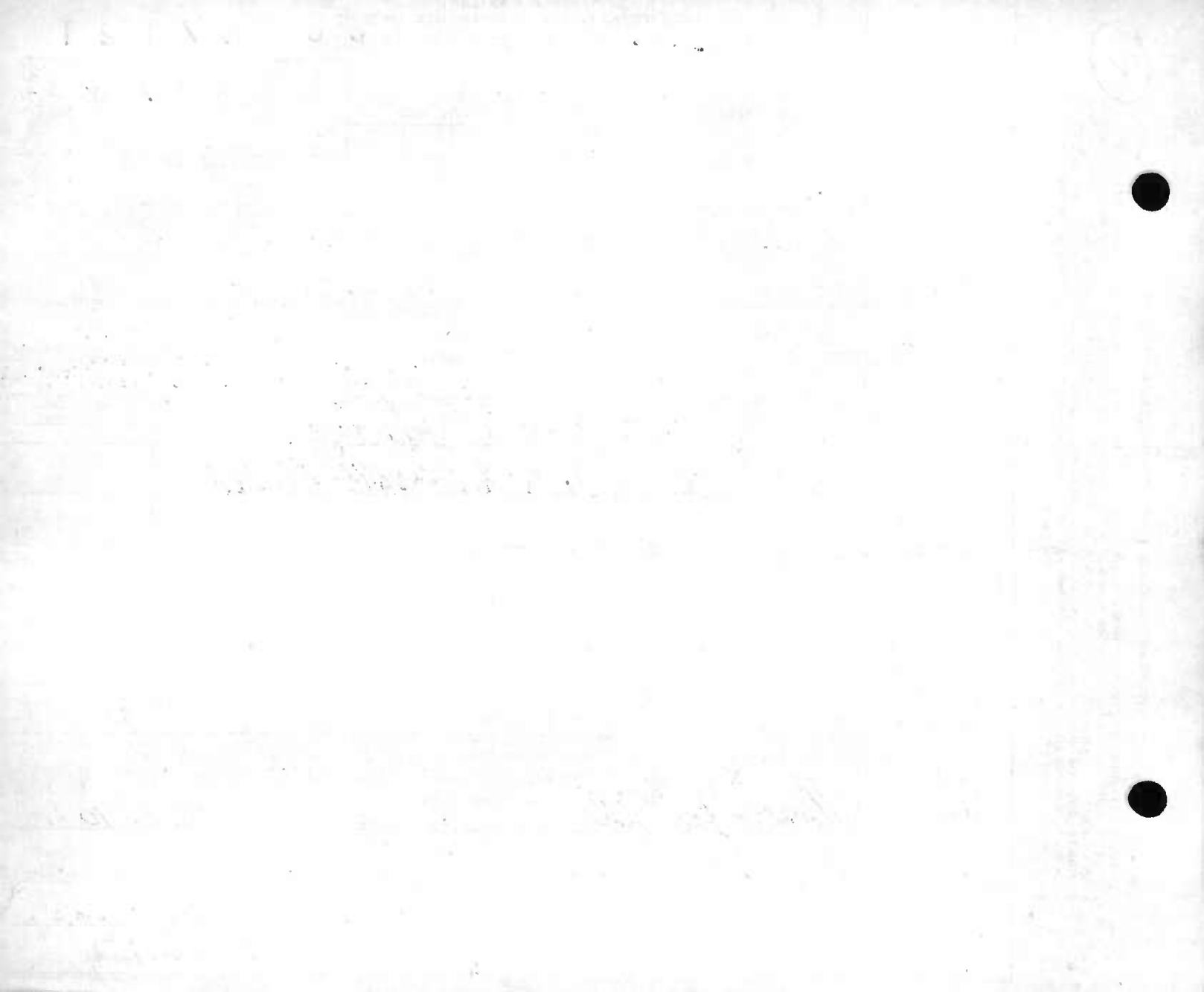
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 27120	
1. DECEASED NAME (TYPE OR PRINT) LAST <i>PRYOR</i> FIRST <i>JAMES</i> MIDDLE <i>HAROLD</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10-15-80</i>		2b. HOUR <i>1:00</i> M
3 SEX <i>Male</i>	4 RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2-3-1897</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Honolulu</i> MD.		
10. CITY OR TOWN OF DEATH <i>Shaw H. H.</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <i>HARRISON House</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Insurance Agent</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>VA.</i>	13b. COUNTY <i>Accomack</i>	13c. CITY OR TOWN <i>ONANCOCK</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <i>KERR</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JAMES E. PRYOR</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>DOLLY CROCKETT PRYOR</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>	16b. SOCIAL SECURITY NO. <i>W.W.I. 214-10-9606</i>	17. INFORMANT ADDRESS <i>MRS. NANCY LONG - ONANCOCK VA.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Chronic Myocardial Disease</i> (c) <i>DUE TO, OR AS A CONSEQUENCE OF</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION <i>9/9</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Donald Jones</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/15/80</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DR. TOM JONES</i>		22e. ADDRESS <i>Paul St. Shaw H. H. 9163</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	23b. DATE <i>10-18-80</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MT. HOLLY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ONANCOCK ACCOMACK VA.</i>	
24. FUNERAL DIRECTOR NAME <i>TOM WILLIAMS</i>		ADDRESS <i>ONANCOCK VA.</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 22 1980</i>	
				25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 27121		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Francis Townsend										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 4 19 80		2b. HOUR 57 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3/24/1902	6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD Oct. 7 19 80		2d. HOUR 80 M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.						
10. CITY OR TOWN OF DEATH Pocomoke		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 3, Stockton Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber & carpenter		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 3, Stockton Road				
14. FATHER'S NAME FIRST MIDDLE LAST Charlie Alfred Townsend				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Wilsie Pruitt								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-09-1539A		17. INFORMANT (brother) Mr. Perless Townsend, Salisbury, Md.		ADDRESS 337 Barclay St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>Thomas L. Jones</u>		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER				DATE SIGNED 10/10/80				
EXAMINER'S NAME (TYPE OR PRINT) Thomas L. Jones, M.D.		ADDRESS 112 Pearl St., Snow Hill, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/9/1980		23c. NAME OF CEMETERY OR CREMATORY Beth Eden Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE R.D. Pocomoke, Worcester, Md.						
24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md.				25a. DATE REC'D. BY REGISTRAR OCT 14 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia A. Roberts</u>						



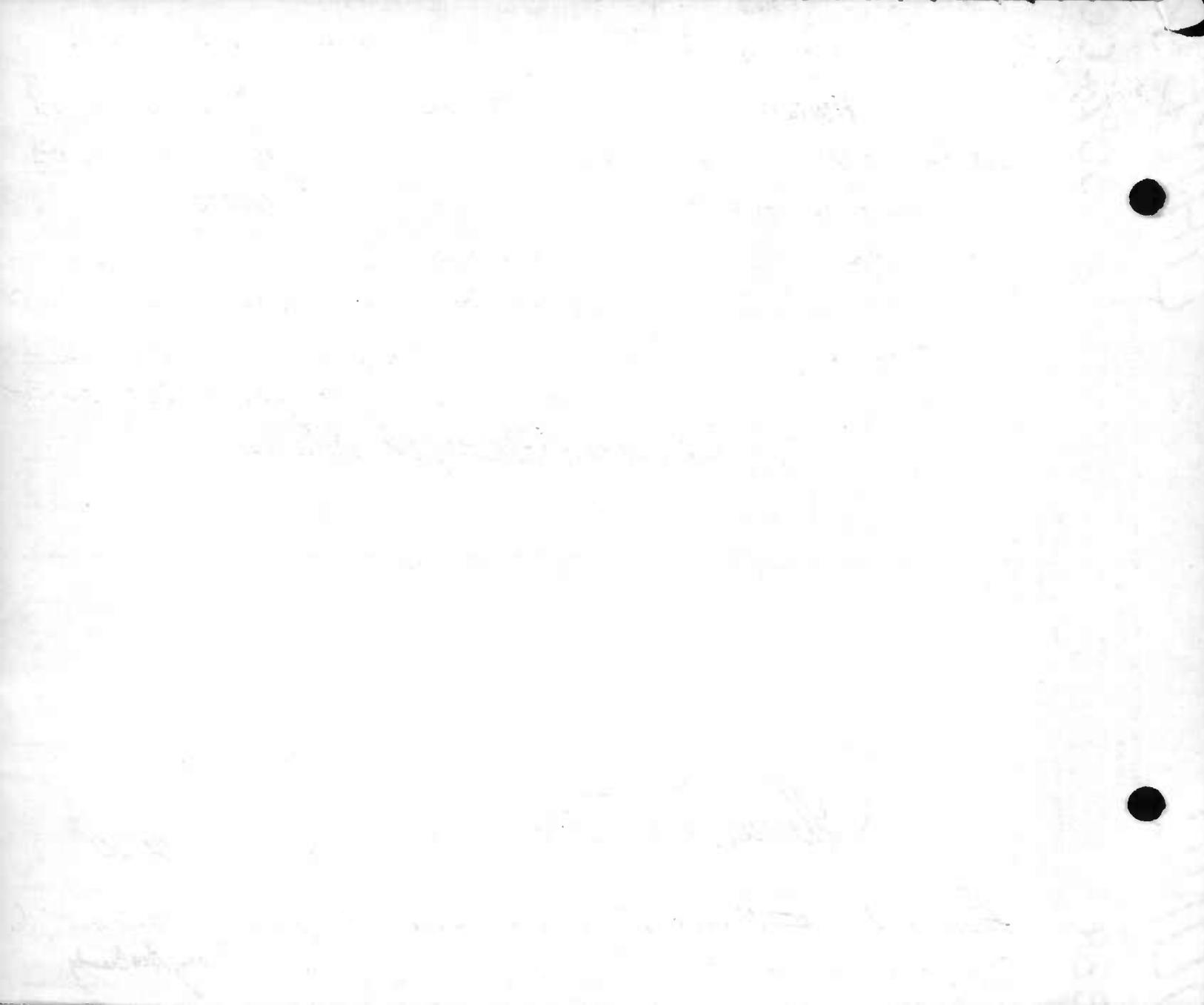
FOR STATE
HEALTH DEPT.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

27122

1. DECEASED-NAME (Type or Print)			First HOWARD	Middle	Last TRADER	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 10 11 1980			2b. HOUR 10:45 M	
3. SEX Male	4. RACE Blk	5. DATE OF BIRTH 11/26/10	6. AGE (in years last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 10 11 1980		2d. HOUR 10:45 M
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WORCESTER Md.				
10. CITY OR TOWN OF DEATH Pocomoke			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RFD Box 290			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY Laborer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Wor.		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD 1 Box 290	
14. FATHER'S NAME First Middle Last Elizah Trader			15. MOTHER'S MAIDEN NAME First Middle Last Maggie Barker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-03-4035		17. INFORMANT Lois Barker			ADDRESS RFD 1 Box 33		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic obstructive pulmonary disease 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Thomas J. D. [Signature]			EXAMINER'S NAME (Type) Thomas J. D. [Signature]			M.D.			22b. DATE SIGNED 10/21/80	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 10/28/80		23c. NAME OF CEMETERY OR CREMATORY 1st Bpt. Cem			23d. LOCATION (City or Town) (County) (State) Marysville Worcester, Va.		
24. FUNERAL DIRECTOR Reith J. D. [Signature]			ADDRESS Accomac, Va.			25a. REC'D BY REGISTRAR DATE OCT 28 1980		25b. REGISTRAR'S SIGNATURE [Signature]		

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours
after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1,
2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3.
Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) HAROLD		FIRST William MIDDLE Harold LAST WALKER		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 2, 1980		2b. HOUR 11:30A.M.	
3 SEX MALE		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 20, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 79-80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Berlin MD Worcester Co MD	
10 CITY OR TOWN OF DEATH Berlin		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Worton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST James Wesley Walker		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosa Ella Barnes		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-07-7128	
17 INFORMANT Brother		ADDRESS R.D.#2, Box 1612		18 J. Finley Walker, Smyrna, Del. 19977			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

CARDIAC ARRESTAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH4292
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (IMMEDIATE)**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

CARDIAC ARRYTHMIA

19a. DATE OF OPERATION 10/1/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/1/80 to 10/2/80 , that (I) (we) last saw the deceased alive on 10/1/80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul A. Scott, M.D.				DEGREE M.D.		22c. DATE SIGNED 10/2/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. SCOTT, M.D.				22e. ADDRESS 24 BROAD ST. BERLIN MD.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 3, 1980		23c. NAME OF CEMETERY OR CREMATORY Stevensville Cemetery, Stevensville, O.A.Co. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24 FUNERAL DIRECTOR NAME Barton Bros.				ADDRESS James H. Barton, Jr., Centreville, Md. 21617		25a. DATE RECEIVED BY REGISTRAR 10/3/80	
25b. REGISTRAR'S SIGNATURE [Signature]							

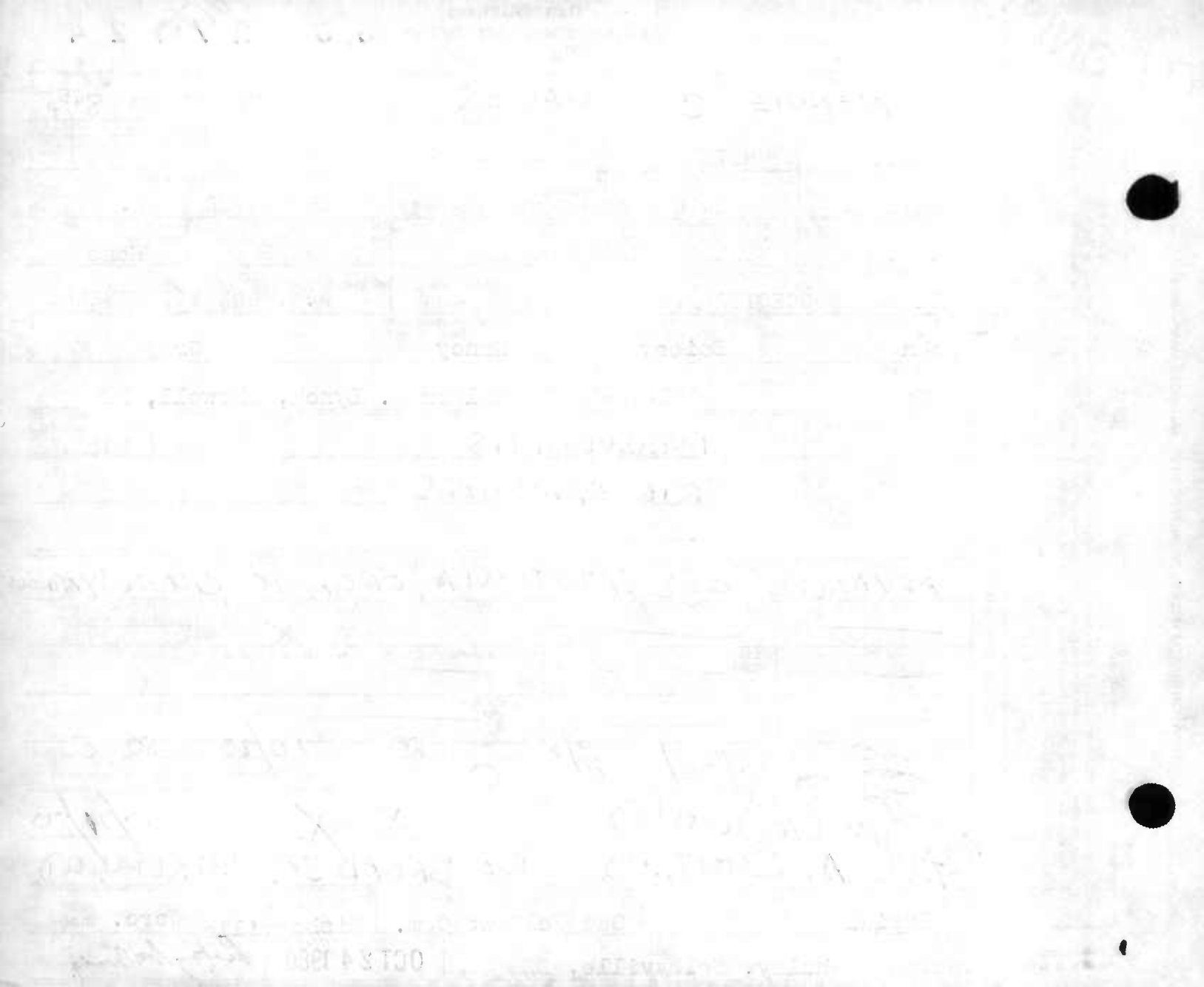
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 0 2 7 1 2 4		CERTIFICATE OF DEATH		REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) NANNIE C WALKER				2a DATE OF DEATH MONTH DAY YEAR 10 20 80		2b HOUR 845 P.M.			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 11- 05- 86		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? AMERICAN		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD			
10 CITY OR TOWN OF DEATH BERLIN, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY Home	
13a STATE MARYLAND		13b COUNTY WORCESTER		13c CITY OR TOWN SHOWELL		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS P.O. BOX 20, SHOWELL, MD	
14 FATHER'S NAME FIRST MIDDLE LAST John Daisey				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy Gray					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-10-2553		17 INFORMANT ADDRESS Kathleen E. Lynch, Showell, MD					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONITIS 7331 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DO NOT WRITE IN THESE SPACES (b) RIB FRACTURES DO NOT WRITE IN THESE SPACES (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WK.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ADVANCED AGE, AZOTEMIA, ORGANIC BRAIN SYNDROME									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22 I certify that (I) (this hospital) attended the deceased from 9/3 19 80 to 10/20 19 80 that (I) (we) last saw the deceased at 10/20 19 80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death									
22a SIGNATURE Dr. A. Scott				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/20/80	
22b PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. SCOTT, MD.				22e ADDRESS 24 BROAD ST. BERLIN, MD.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE		23c NAME OF CEMETERY OR CREMATORY Odd Fellows Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Bishopville Worc. MD.			
24 FUNERAL DIRECTOR NAME ADDRESS Watson & Whaley, Selbyville, DE				25a DATE REC'D. BY REGISTRAR OCT 24 1980		25b REGISTRAR'S SIGNATURE Henry McCready			

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Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified per one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARTHA T. WILLIAMS			2a. DATE OF DEATH MONTH 10 DAY 19 YEAR 80			2b. HOUR 8:40 P.M.	
3 SEX Female		4 RACE W		5 DATE OF BIRTH MONTH 4 DAY 13 YEAR 1887		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD.	
10 CITY OR TOWN OF DEATH Berlin Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nuts. Home Berlin Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Berlin Md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS							
14. FATHER'S NAME FIRST CHARLES MIDDLE EVERSON LAST EVERSON				15. MOTHER'S MAIDEN NAME FIRST ELEANOR MIDDLE MEEKER LAST MEEKER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 221-16-7047		17 INFORMANT ADDRESS CLARA TRIMBLE - BERLIN, MD.			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		—
(b) MYOCARDIAL INFARCTION		
(c) —		—

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

CONGESTIVE HEART FAILURE

19a. DATE OF OPERATION 10/17/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/7 19 80 to 10/19 19 80 , that (I) (we) last saw the deceased alive on 10/17 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Paul A. Scott MD.				DEGREE		22c. DATE SIGNED 10/20/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. SCOTT MD.				22e. ADDRESS 24 BROAD ST. BERLIN, MD 21811			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-22-80		23c. NAME OF CEMETERY OR CREMATORY ROXANA CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ROXANA, SUSSEX, DEL	
24. FUNERAL DIRECTOR NAME CLERKA FUNERAL HOME ADDRESS BERLIN, MD.				25a. DATE REC'D. BY REGISTRAR OCT 29 1980		25b. REGISTRAR'S SIGNATURE Holmes/Kelley	

BP

10-22-80 Kansas City, Mo.
Kansas City, Mo.

10
Charles Peterson
Farmington, N.H.

10-22-80
at home